BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **SUSAN B. FLEMING, M.D.** License No. 14840 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-06-0438A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Susan B. Fleming, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges she has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any

waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

12. Respondent has read and understands the condition(s) of probation.

SUSAN B. FLEMING, M.D.

DATED: 3/6/07

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 14840 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0438A after receiving a complaint regarding Respondent's care and treatment of a forty-eight year-old male patient ("CR").

4. On July 20, 2005, CR presented to Respondent with a three to four month history of upper back pain and "low grade" chronic low back pain that was periodically exacerbated by his lifting activities. Respondent performed a physical examination and prescribed #50 Oxycodone 5 mg q 4 hours prn pain. Respondent recommended myofascial release, therapeutic exercise, consultation with a surgeon regarding a possible inguinal hernia, and follow up in one month if needed.

5. Between August 2, 2005 and September 16, 2005 CR returned to Respondent's office five times requesting early Oxycodone refills. By September 16, 2005 Respondent was prescribing #300 Oxycodone 15 mg 1-2 q 4 hours for pain. After each visit Respondent scheduled CR for follow up in one month. Respondent performed a limited physical examination at each visit including completing a pre-printed questionnaire describing CR's development and nutrition.

6. On September 29, 2005 CR returned for an early follow up visit with Respondent stating that his planned hernia surgery was rescheduled and that he was "using a bit more pain medication" because he is working harder in anticipation of surgery. Respondent provided an early refill of #300 Oxycodone. Respondent refilled the prescription again on October 14, 2005 following CR's hernia surgery because CR had more pain than expected.

7. Respondent provided early refills of #300 Oxycodone 15 mg 1-2 q 4 hours prn pain four more times between November 1, 2005 and January 3, 2006.

8. At a January 19, 2006 visit Respondent noted CR admitted to using more Oxycodone (12-15 tablets per day) than usual do to strenuous physical work. Respondent performed a limited physical examination and noted CR to be "stable on medications." Respondent also noted that CR's use of opioids would not be short term and requested CR sign an opioid agreement.

9. At a January 27, 2006 office visit, CR reported that he had been involved in a motor vehicle accident on January 23, 2006. Respondent documented his recent history and her examination. Later that day, CR reported by telephone that his medications had been stolen. Respondent provided a prescription for Oxycodone on February 2, 2006, when CR was in the office for physical therapy.

10. On February 17, 2006 Respondent's office received a telephone call from a pharmacy expressing the pharmacist's concerns that CR filled his Oxycodone prescriptions every 17-18 days, indicating that he was not following his prescription directions. Respondent gave her office staff instructions to inform the pharmacy not to fill the prescription and to "make him [CR] follow the directions."

11. CR returned to Respondent's office on March 10, 2006 complaining of pain from a broken tooth and dental infection and stated the dentist was currently unavailable. Respondent provided an Oxycodone refill and recommended CR return in one month for follow up. CR returned on March 30, 2006 and Respondent noted he used "a bit more Oxycodone" than usual following dental extraction. Respondent provided a seventeen day supply of Oxycodone and recommended CR return in one month. CR returned on April 19, 2006 and Respondent noted he was using Oxycodone as needed for ongoing dental work. Respondent noted CR was "stable on current medications."

12. On May 9, 2006 CR was seen by Respondent's medical assistant ("MA"). MA noted CR reported to have run out of medications on Saturday, but there was no reason for his early depletion of medications. MA scheduled CR for a urine drug screen on his next visit. Respondent reviewed the history, physical and plan of care for CR.

13. On May 25, 2006 Respondent confronted CR about a message from CR's sister concerning his opioid usage. CR stated he "is using a lot more medication and is not happy with the situation." Respondent planned to wean CR's off his medications and prescribed #100 Oxycodone 15 mg with instructions to take only 10 Oxycodone per day. Respondent also prescribed #90 Lorazepam 1.0 mg tid to help with withdrawal symptoms. Respondent did not document her instructions to CR regarding the addition of Lorazepam. Respondent made no note of the urine drug screen that was planned for this visit, but did advise CR that no further early refills would be provided. That day, CR was admitted to the hospital emergency room after he was involved in an automobile accident with his mother and six year old child as passengers. CR informed hospital staff he filled his prescriptions for Oxycodone and Lorazepam that day. CR admitted to taking two Oxycodone and four Lorazepam tablets. However, the emergency room physician noted thirteen Oxycontin and sixteen Lorazepam tablets were missing from their containers. CR was overheard making homicidal threats to his mother and was determined to be a danger to others and required hospitalization. The emergency room physician copied Respondent on his dictated report, but Respondent stated she did not receive it.

14. CR was discharged from the hospital on May 30, 2006. During his hospitalization he reported that "he may have been using his medications more than prescribed" and admitted to impulsive behavior in taking his medications. CR's urine drug screen was positive for opiates, cannabinoids, and tricyclics. He was diagnosed with polysubstance abuse and untreated depression.

15. On June 1, 2006 CR returned for a follow up visit with Respondent and reported to have reduced his Oxycodone use to ten tablets per day. Respondent instructed him to decrease this to eight tablets per day. Respondent did not document a physical examination and recommended follow up in two weeks.

16. Respondent was not aware that CR had been hospitalized in May 2006 until she received notice from the Board on June 8, 2006 of a complaint filed against her by CR's sister.

17. CR returned to Respondent's office on June 15, 2006. Respondent noted CR had been taking eight tablets of Oxycodone per day and provided him with a prescription for #50 Oxycodone 15 mg with instructions to take only six per day. At this visit CR informed Respondent he took a mild overdose of Lorazepam and was hospitalized. Respondent obtained a release in order to obtain the hospital records. On June 22, 2006, after receiving the hospital records and determining CR had not been truthful regarding the hospitalization, Respondent informed CR she would no longer prescribe opiates to him.

18. The standard of care requires a physician to adequately perform an examination of a patient prior to prescribing medications. The standard of care requires a physician to properly prescribe medications, closely monitor for, recognize and follow up on problems suggestive of non-compliance and/or aberrant drug seeking behavior when prescribing long term opioids for chronic pain. The standard of care also requires a physician monitoring a patient's chronic pain to coordinate care with other treating physicians so as not to manage acute post-operative pain without the knowledge of and/or the express consent of the treating physicians.

19. Respondent deviated from the standard of care by failing to perform an adequate physical examination on CR prior to prescribing Oxycodone refills. Respondent's examination included completing a pre-printed questionnaire describing CR's development

and nutrition. Respondent deviated from the standard of care by failing to properly prescribe Oxycodone for minor injuries and for failing to recognize and follow up on problems suggestive of substance abuse and a violation of an opioid agreement occurring between August 2005 and June 2006. Respondent also deviated from the standard of care by approving CR's use of Oxycodone to treat post-extraction dental pain and pre and post-operative hernia discomfort without informing the physicians treating CR for these conditions and/or without their express consent.

20. Respondent's inappropriate prescribing perpetuated CR's inappropriate drug seeking behavior and addiction.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for improper prescribing, inadequate examination of the patient, prescribing in excess of findings reported and failure to recognize or deal with evidence of narcotics abuse on several occasions.

2. Respondent is placed on probation for **one year** with the following terms and conditions:

A. Continuing Medical Education

Respondent shall within **one year** of the effective date of this Order obtain twenty hours of Board Staff pre-approved Category I Continuing Medical Education (CME) in prescribing and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license. The probation shall terminate upon successful completion of the CME.

B. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court order criminal probation, payments and other orders.

C. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. This Order is the final disposition of case number MD-06-0438A.

DATED AND EFFECTIVE this 23rd day of April, 2007.

ARIZONA MEDICAL BOARD

(SEAL)

By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 30th day of August, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 30th day of August, 2007 to:

Sandra J. Rogers
Campbell, Yost, Clare & Norell, P.C.
33 N. Stone Avenue, Suite 1850
Tucson, AZ 85701-1426

EXECUTED COPY of the foregoing mailed this 30th day of August, 2007 to:

Susan B. Fleming, M.D.
Address of Record

Chris Camp
Investigational Review